ANTHEM BLUE CROSS & BLUE SHIELD

Large Group Employment Master Contract and Rider

Denver City Clerk's Filing No. 2011-0978

Filed 09.10.2012

LARGE GROUP EMPLOYMENT MASTER CONTRACT RIDER

THIS RIDER is attached to, incorporated in and made part of the foregoing Large Group Employer Master Contract (the "Policy") by and between Anthem Blue Cross and Blue Shield (Anthem) or HMO Colorado health, dental and/or vision plan (collectively referred to as the "Company"), and the City and County of Denver (herein the "Employer"). The terms and conditions of the Rider supersede the terms of the Large Group Employer Master Contract, and, should there be any conflict or inconsistency between this Rider and the Large Group Employer Master Contract, the terms and conditions of this Rider shall prevail. By acceptance and execution of the Rider, the Company agrees to the following provisions:

I) General Changes to the Policy

A) THE FOLLOWING PARAGRAPHS ARE HEREBY DELETED FROM THE POLICY:

i) Section 1, Paragraph 8
ii) Section 1, Paragraph 14
iii) Section 1, Paragraph 15
iv) Section 4, Paragraph 10(d)
v) Section 5, Paragraph 21

B) THE FOLLOWING PARAGRAPHS IN THE POLICY ARE REWRITTEN TO READ AS FOLLOWS:

i) Section 1:10

The failure of either party to enforce or insist on compliance with any provision of this Contract will not be construed as or constitute an election or waiver of the right to enforce or insist on compliance with such provision in the future.

No failure or delay by the Company or Employer to exercise any right or to enforce any obligation under this Contract, and no course of dealing between the Employer and the Company, will operate as an election or waiver of such right or obligation. No single or partial exercise of any right or failure to enforce any obligation under this Contract will prevent any other or further exercise thereof or the right to exercise any other right or enforce any other obligation.

ii) Section 1:12(b)

The company may terminate the Contract at any time during its term upon giving the Employer thirty-one (31) days' advance written notice of termination (i) if the Employer fails to meet eligibility requirements; (ii) if the Employer fails to maintain enrollment percentage requirements as provided in the application; (iii) for misrepresentation of material facts or for any other material breach of the Contract; (iv) if the Employer commits a fraudulent act (when

this occurs, the Company will recover paid claims); (v) if the Employer does not remit to the Company any assessment billed for CoverColorado or any similar state or federal program; or (vi) for any reason as permitted by applicable law or regulation, upon giving the Employer such advance notice, if any, as may be required by such law or regulation.

iii) Section 1:15

The Company reserves the right to change the benefit provisions under this Contract, effective on the Anniversary Date, by giving written notice to the Employer not less than ninety (90) days before the effective date of such change; however, such notice requirement will not apply to changes in benefit provisions that are required by state or federal law or regulation. If the Employer requests a change to the benefit provisions under this Contract, it shall give the Company at least forty-five (60) days' advance written notice of the requested change.

If any change to the benefits or the payment amounts is unacceptable to the Employer, the Employer will have the right to terminate coverage under this Contract by giving written notice of termination to the Company before the effective date of the change. The schedule and/or addenda will then become a part of this Contract.

iv) Section 2:2

The Company will deliver to each subscriber's last address appearing in the Company's records a health benefit ID card upon receipt of this information to the company from the Employer. The Company will provide the Employer with an electronic and/or written copy of a membership certificate, which will describe the features of the coverage, including any applicable conversion or continuation privilege, and to whom the benefits are payable, as well as an electronic copy of the then-current provider directory. The Employer agrees that the Company may, upon advance notice to the Employer, deliver certificates, ID cards, benefit booklets, provider directories or other materials to the Employer and/or Member via electronic means or via Internet access, where permitted by law.

v) Section 3:4(a)

The Employer will keep such records and furnish to the Company such notification and other information as the Company may require for the purpose of enrolling Members, processing terminations, effecting changes in single or family contract status, effecting changes due to a Member becoming eligible for Medicare, effecting changes due to a Member becoming disabled or being eligible for short-term or long-term disability, determining the amount payable by the Employer under this Contract, or for any other purpose reasonably related to the administration of this Contract. This will include, but is not limited to, the handling of ongoing additions, deletions and changes on a timely basis. The Employer will be responsible for retaining in auditable form complete eligibility documentation, whether written or in electronic form, including, but not limited to, all electronic or written enrollment information, any electronic or written confirmation forms or media, and any electronic or written

correspondence related to the eligibility and declination forms. The Employer must procure the Company's prior approval of any non-standard forms to be used in obtaining eligibility information. The Employer warrants that the electronic enrollment processes and media are maintained in a secure manner, are retrievable and reproducible, with the enrollment and signature linked with the process or media. In addition, the Employer warrants that the manner of electronic signature satisfies all legal requirements for an electronic signature.

vi) Section 3:4(b)

The Employer shall advise the Company when the Employer has notice that a Member is no longer employed by the Employer or otherwise does not meet membership requirements. The Employer shall so notify the Company, at the latest, by the first Service Date after a Member ceases to be employed by the Employer or otherwise ceases to meet membership requirements. The Employer agrees that no person will be kept on the Employer's payroll or otherwise be represented as a Member for the principal or sole purpose of obtaining or maintaining coverage under this Contract.

vii) Section 3:8

Initial premium shall become payable on the 25th day of the effective month of the Contract. Subsequent premiums will be payable on the 25th day of each month thereafter. Claims processing and payment will be pended if premium is not timely paid. In no event shall coverage under the Contract become effective until the Company accepts the application and the Company receives payment of the initial premium.

viii) Section 4:2(a)

Applications will be submitted on behalf of all eligible new or transferred Members who want to enroll at the time of hiring, transfer or other eligibility. Applications will specify the date of hire for new employees, the date of transfer for transferred employees, or the date of eligibility for other new participants. However, such employee may be required to complete a health questionnaire as part of the application process, and the answers the employee supplies on the questionnaire will not prevent enrollment.

ix) Section 4:4

An eligible Member who did not request enrollment for coverage during the initial enrollment period or special enrollment period, or a newly eligible dependent who failed to qualify when first entitled to enroll, may apply for coverage as a late enrollee. Such Member may only enroll during an annual enrollment and may be required to complete a health questionnaire as part of the application process, and the answers such Member supplies on the questionnaire will not prevent enrollment.

x) Section 4:5(b)

Enrollment under provision (a) must be requested no later than thirty-one (31) days after the date the coverage described above terminated or the date the person becomes a dependent of an eligible employee. If enrollment is not requested within the required thirty-one (31) days, the person will be considered a late enrollee. Such employee or dependent may be required to complete a health questionnaire as part of the application process, and the answers supplied by the employee or dependent on the questionnaire will not prevent enrollment.

xi) Section 4:5(d)

Enrollment under provision (c) must be requested no later than sixty (60) days after the date that state Medicaid coverage terminated, or ninety (90) days after the date that SCHIP coverage terminated. With respect to premium assistance eligibility, enrollment under the employer plan must be requested no later than sixty (60) days after the eligibility date for assistance is determined. If enrollment is not requested within these timeframes, the person will be considered a late enrollee. Such employee or dependent may be required to complete a health questionnaire as part of the application process, and the answers supplied by the employee or dependent on the questionnaire will not prevent enrollment.

II) Additional/Miscellaneous Terms

A) Definitions:

Dependent Child Age Limits: A child shall be covered to the end of the month that he/she turns age 26 and unmarried legal dependents who are mentally or physically disabled shall be covered regardless of age, all of whom must also be legal dependents of the Insured Employee or of a spousal equivalent.

Eligible Dependents are any spouse, including those defined as common-law under the state, spousal equivalent, or child meeting the Dependent Age Limits (including a step-child, child for whom the Insured Employee, his/her spouse, or his/her spousal equivalent is required by a qualified medical child support order to provide health care coverage (even if the child does not reside at the same legal residence of the parent), a child for whom you or your spouse has court-ordered custody, or adopted child or child placed for adoption), or unmarried incapacitated and physically disabled children who are legal dependents of the Insured Employee or legal dependents of a spousal equivalent, of an Insured Employee, who meet the eligibility requirements and for whom applicable Dues are received.

An Eligible Employee is an employee who works a fixed number of hours established by the Group, meets any other eligibility requirements as set forth in Code Section 18-171 of the Denver Revised Municipal Code ("Denver Code"), or is an eligible employee of the Denver Employees' Retirement Plan (DERP), or is an eligible retired member of DERP who is not eligible

for Medicare, and who satisfies any applicable waiting period of Group, and meets the following additional criteria:

a) If not retired, is defined as an employee under State and Federal Law; and
b) Persons listed under "with the exception of:" as set forth in Denver Code Section 18-171 (1)(a) through (d) are not Eligible Employees.

Spousal equivalent is defined as an adult of the same gender who shares an emotional, physical, and financial relationship with the employee, similar to that of a spouse. A Subscriber of the group may enroll a sole spousal equivalent of the same sex and children of the sole spousal equivalent as Eligible Dependents. A sole spousal equivalent is a person who meets the following requirements for eligibility:

a) Is 18 years of age or older;
b) Is mentally competent to consent to contract;
c) Has an exclusive, committed relationship with the Subscriber with the intent for the relationship to last indefinitely;
d) Shares basic living expenses with the Subscriber;
e) Is unmarried; and
f) Is not related by blood to the Subscriber such as a parent, brother, sister, half brother, half sister, niece, nephew, aunt, uncle, grandparent or grandchild.

B) MAXIMUM CONTRACT AMOUNT:

Notwithstanding any other provision of the Agreement, the City's maximum payment obligation will not exceed SEVEN HUNDRED THOUSAND dollars ($700,000.00) (the "Maximum Contract Amount"). The City is not obligated to execute an Agreement or any amendments for any further services, including any services performed by Company beyond that specifically described in Policy and Rider. Any services performed beyond those set forth therein are performed at the Company's own risk and without authorization.

The City's payment obligation, whether direct or contingent, extends only to funds appropriated annually by the Denver City Council, paid into the Treasury of the City, and encumbered for the purpose of this Policy and Rider. The City does not by this Policy or Rider irrevocably pledge present cash reserves for payment or performance in future fiscal years, and the Policy and Rider does not and is not intended to create a multiple-fiscal year direct or indirect debt or financial obligation of the City.

C) SHIPPING, TAXES AND OTHER CREDITS AND CHARGES:

Company shall procure all permits and licenses; pay all charges, taxes and fees; and give all notices necessary and incidental to the fulfillment of the Policy and all cost thereof have been included in the prices contained herein. City shall not be liable for the payment of taxes, late charges or penalties of any nature, except as required by D.R.M.C. § 20-107, et seq. The price of all goods/services shall reflect all applicable tax exemptions. City's Federal Registration No. is

84-6000580 and its State Registration No. is 98-02890. Company shall not impose any charges for boxing, crating, parcel post, insurance, handling, freight, express or other similar charges or fees. Company shall pay all sales and use taxes levied by City on any tangible personal property built into the goods/services. Company shall obtain a Certificate of Exemption from the State of Colorado Department of Revenue prior to the purchase of any materials to be built into the goods/services and provide a copy of the Certificate to City prior to final payment.

D) AMENDMENTS/CHANGES:

Only the Director of Career Service Authority or his/her delegate is authorized to change or amend this Policy or Rider by a formal written amendment. Any change or amendment that would cause the aggregate payable under this Policy to exceed the amount appropriated and encumbered for this Policy is expressly prohibited and of no effect. Company shall verify that the amount appropriated and encumbered is sufficient to cover any increase in cost due to changes or amendments. Goods/services provided without such verification are provided at Company's risk. The Company has no authority to bind City on any contractual matters.

E) INDEMNIFICATION/LIMITATION OF LIABILITY:

Company shall indemnify and hold harmless City (including but not limited to its employees, elected and appointed officials, agents and representatives) against any and all losses (including without limitation, loss of use and costs of cover), liability, damage, claims, demands, actions and/or proceedings and all costs and expenses connected therewith (including without limitation attorneys' fees) that arise out of or relate to any claim of infringement of patent, trademark, copyright, trade secret or other intellectual property right related to this Policy or that are caused by or the result of any act or omission of Company, its agents, suppliers, employees, or representatives. Company's obligation shall not apply to any liability or damages which result solely from the negligence of City. City shall not be liable for any consequential, incidental, indirect, special, reliance, or punitive damages or for any lost profits or revenues, regardless of the legal theory under which such liability is asserted. In no event shall City's aggregate liability exceed the agreed upon cost for those goods/services that have been accepted by City under this Policy up to the Total Policy Amount. Notwithstanding anything contained in this Policy to the contrary, City in no way limits or waives the rights, immunities and protections provided by C.R.S. § 24-10-101, et seq.

F) ASSIGNMENT/NO THIRD PARTY BENEFICIARY:

Notwithstanding anything herein to the contrary, Company may, upon notice to City, assign or otherwise transfer its rights, benefits, duties, and obligations hereunder, in whole or in part, to any affiliate of Company or any entity surviving a transaction involving the merger, consolidation, or reorganization of Company, or in which all or substantially all of Company's assets are sold; in which case Company remains liable under this Policy and the affiliate or survivor shall be bound by the terms and conditions herein.

G) NOTICE:

Notices shall be made by Company to the Director of Career Service Authority or his/her delegate in writing sent registered, return receipt requested to:

Director of Career Service Authority
Wellington E. Webb Municipal Office Building
201 West Colfax Avenue, Dept. 412 (4th Floor)
Denver, CO 80202

H) COMPLIANCE WITH LAWS:

Company shall observe and comply with all federal, state, county, city and other laws, codes, ordinances, rules, regulations and executive orders related to its performance under this Contract and Rider. City may immediately terminate this Contract and Rider, in whole or in part, if Company or an employee is convicted, plead nolo contendre, or admits culpability to a criminal offense of bribery, kickbacks, collusive bidding, bid-rigging, antitrust, fraud, undue influence, theft, racketeering, extortion or any offense of a similar nature.

I) INSURANCE:

Company shall secure, before delivery of any goods/services, the following insurance covering all operations, goods and services provided to City. Company shall keep the required insurance coverage in force at all times during the term of the Contract and Rider, or any extension thereof, and for three (3) years after termination of this Contract and Rider. The required insurance shall be underwritten by an insurer licensed or authorized to do business in Colorado and rated by A.M. Best Company as "A-"VIII or better. Company agrees to provide notification to the City in the event any of the required policies are canceled or non-renewed before the expiration date thereof; provided, however that Company shall not be obligated to provide such notice if, concurrently with such cancellation or non-renewal, Company obtains coverage from another insurer meeting the requirements described above. Upon change of carriers, revised certificates of insurance will be provided. Such notice shall be sent to the parties identified in the Notices section of the Contract. Such written notice shall be sent thirty (30) days prior to such cancellation or reduction unless due to non-payment of premiums for which notice shall be sent ten (10) days prior. If such written notice is unavailable from the insurer, Company shall provide written notice of cancellation or non renewal to the parties identified in the Notices section by certified mail, return receipt requested, within three (3) business days of notice from its insurer(s). If any policy is in excess of a deductible or self-insured retention, City must be notified by Company. Company shall be responsible for the payment of any deductible or self-insured retention. The insurance coverages specified in this Policy are the minimum requirements, and these requirements do not lessen or limit the liability of Company. The Company shall maintain, at its own expense, any additional kinds or amounts of insurance that it may deem necessary to cover its obligations and liabilities under this Agreement. Company

shall provide a copy of this Policy to its insurance agent or broker. Company may not commence services or work relating to the Contract prior to providing a certificate of insurance. Contractor certifies that the certificate of insurance, preferably an ACORD certificate, complies with all insurance requirements of this Agreement. The City's acceptance of a certificate of insurance or other proof of insurance that does not comply with all insurance requirements set forth in this Agreement shall not act as a waiver of Contractor's breach of this Agreement or of any of the City's rights or remedies under this Agreement. The City's Risk Management Office may require additional proof of insurance For Commercial General Liability Company's insurer shall name City and County of Denver, its elected and appointed officials, employees and volunteers as additional insured as their interests may appear with regards to losses arising out of the administration of this contract TO the extent permitted by law, Company's Commercial General liability insurer shall waive subrogation rights against City. All subcontractors and subconsultants (including independent contractors, suppliers or other entities providing goods or services required by this Agreement) shall be subject to all of the requirements herein and shall procure and maintain coverages required by the Company. Company shall ensure that all such subcontractors and subconsultants maintain the coverages as per the Company's contract with the subcontractor or subconsultant. Company agrees to provide proof of insurance for all such subcontractors and subconsultants upon request by the City.. For Worker's Compensation Insurance, Company shall maintain the coverage as required by statute for each work location and shall maintain Employer's Liability insurance with limits of $100,000 for each bodily injury occurrence claim, $100,000 for each bodily injury caused by disease claim, and $500,000 aggregate for all bodily injuries caused by disease claims. Company expressly represents to City, as a material representation upon which City is relying, that none of the Company's officers or employees who may be eligible under any statute or law to reject Workers' Compensation Insurance shall effect such rejection during any part of the term of this Contract and Rider, and that any such rejections previously effected, have been revoked. Company shall maintain Commercial General Liability coverage with limits of $1,000,000 per occurrence, $1,000,000 personal and advertising injury, $2,000,000 products and completed operations, and $2,000,000 policy aggregate. Company shall maintain Business Auto Liability coverage with limits of $1,000,000 combined single limit applicable to all vehicles providing services under this Contract. Company shall maintain Managed Care Errors and Omissions Insurance with limits of $5,000,000 per claim and in the aggregate. Policy shall include a provision that coverage is primary and non-contributory with other coverage or self-insurance maintained by the City. For Commercial General Liability coverage, the policy must contain a provision that coverage is primary and non-contributory with other coverage or self-insurance provided by City. For claims made coverage, the retroactive date must be on or before the first date when any goods or services were provided to City. At their own expense, and where such general aggregate or other aggregate limits have been reduced below the required per occurrence limit, the Company will procure such per occurrence limits and furnish a new certificate of insurance showing such coverage is in force.

J) SURVIVAL AND SEVERABILITY:

If any provision of this Rider or Policy, except for the provisions requiring appropriation and encumbering of funds and limiting the total amount payable by City, is held to be invalid, illegal or unenforceable by a court of competent jurisdiction, the validity of the remaining portions or provisions shall not be affected if the intent of City and Company can be fulfilled.

All terms and conditions of this Rider and Policy which by their nature must survive termination/expiration shall so survive. Without limiting the foregoing, Company's insurance, warranty and indemnity obligations shall survive for the relevant warranty or statutes of limitation period plus the time necessary to fully resolve any claims, matters or actions begun within that period. Bonds shall survive as long as any warranty period.

K) NO CONSTRUCTION AGAINST DRAFTING PARTY:

No provision of this Rider or Policy shall be construed against the drafter.

L) RECORDS AND AUDITS:

Company shall maintain for three (3) years after final payment hereunder, all pertinent books, documents, papers and records of Company involving transactions related to this Contract and Rider, and City shall have the right to inspect, audit and copy the same.

M) REMEDIES/WAIVER:

No remedy specified herein shall limit any other rights and remedies of City at law or in equity. No waiver of any breach shall be construed as a waiver of any other breach.

N) NO DISCRIMINATION IN EMPLOYMENT:

Company shall not refuse to hire, discharge, promote or demote, or to discriminate in matters of compensation against any person otherwise qualified, solely because of race, color, religion, national origin, gender, age, military status, sexual orientation, marital status, or physical or mental disability; and Company shall insert the foregoing provision in any subcontracts hereunder.

O) CONFLICT OF INTEREST:

No employee of City shall have any personal or beneficial interest in the goods/services described in this Contract and Rider; and Company shall not hire or contract for services any employee or officer of City which would be in violation of City's Code of Ethics, D.R.M.C. §2-51, et seq. or the Charter §§ 1.2.8, 1.2.9, and 1.2.12.

P) ADVERTISING AND PUBLIC DISCLOSURE:

Company shall not reference the goods/services provided hereunder in any of its advertising or public relations materials without first obtaining the written approval of the Director of Career Service Authority or his/her delegate.

Q) PROHIBITION OF EMPLOYMENT OF ILLEGAL IMMIGRANTS TO PERFORM WORK UNDER THIS CONTRACT AND RIDER:

This Policy is subject to Article 17.5 of Title 8, Colorado Revised Statutes, as now existing or hereafter amended, (the "Certification Statute"). Compliance by the Contractor and its subcontractors with the Certification Statute is expressly made a contractual condition of this Contract and Rider. The Contractor shall not knowingly employ or contract with an illegal alien to perform work under this Contract and Rider. The Contractor shall not enter into a contract with a subcontractor that knowingly employs or contracts with an illegal alien or that fails to certify to the Contractor that it does not knowingly employ or contract with an illegal alien to perform work under this Contract and Rider. The Contractor represents, warrants, and agrees that: (a) It has verified or attempted to verify that it does not employ any illegal aliens, through participation in the Basic Pilot Employment Verification Program administered by the U.S. Social Security Administration and U.S. Department of Homeland Security ("Basic Pilot Program" or "BPP"), as defined in § 8-17.5-101(1), C.R.S., or that if it is not accepted into the BPP prior to entering into this Contract and Rider, it shall apply to participate in the BPP every three months until either it is accepted into the BPP or its has completed its obligations under this Contract and Rider, whichever occurs first; (b) It will not use the BPP to undertake pre-employment screening of job applicants while performing its obligations under this Contract and Rider; (c) If it obtains actual knowledge that a subcontractor performing work under this Policy knowingly employs or contracts with an illegal alien, it will notify such subcontractor and the City within three days, and terminate such subcontractor if within three days after such notice the subcontractor does not stop employing or contracting with the illegal alien, unless during such three day period the subcontractor provides information to establish that the subcontractor has not knowingly employed or contracted with an illegal alien; (d) It shall comply with all reasonable requests made in the course of an investigation by the Colorado Department of Labor and Employment under authority of § 8-17.5-102(5), C.R.S. If the Contractor fails to comply with any provision of this Section 35, the City may terminate this Policy for breach and the Contractor shall be liable for actual and consequential damages to the City. Contractor shall certify the above by signing the certification attached to this Policy as Exhibit A.

Contract Control Number: 201103544

Vendor Name: ANTHEM BLUE CROSS AND BLUE SHIELD

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of

SEAL

CITY AND COUNTY OF DENVER

ATTEST:

By _____

APPROVED AS TO FORM:

DOUGLAS J. FRIEDNASH, Attorney
for the City and County of Denver

REGISTERED AND COUNTERSIGNED:

By _____

By _____

By _____

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

ATTEST

_____
Debra Johnson, Clerk and Recorder,
Ex-Officio Clerk of the
City and County of Denver

CITY AND COUNTY OF DENVER

By: _____
MAYOR

RECOMMENDED AND APPROVED:

By: _____
Career Service Authority

APPROVED AS TO FORM:
Attorney for the City and County of Denver

By: _____
Assistant City Attorney

REGISTEREDANDCOUNTERSIGNED:

By: _____
Manager of Finance
Contract Control No. _____

By: _____
Auditor

"CITY"

ATTEST:

By: _____

Title: _____

Anthem Blue Cross and Blue Shield
Taxpayer (IRS) Identification
No. _____

By: _____

Title: VP Sales

"Company"

Anthem
Health. Join In.

LARGE GROUP EMPLOYER MASTER CONTRACT

Dear Employer:

We are pleased your organization has submitted an application ("application") for employer group or blanket health coverage under an Anthem Blue Cross and Blue Shield (Anthem) or HMO Colorado health, dental and/or vision plan. You have applied for coverage in a high-quality program. The applying organization, whether an employer, association, union, employee organization, school or other legitimate entity, is referred to as the "Employer" (also referred to as "you," the "group" or the "plan sponsor").

The application will be reviewed by Anthem or HMO Colorado (sometimes referred to as "the Company"), as appropriate. If the application is approved, the Employer will receive a copy of this master contract, the application, any addenda or endorsements, a Member certificate, and an acceptance letter summarizing benefits. These documents will constitute the entire agreement ("Contract") between the Company and the Employer. If any inconsistency exists between the terms of the application and the terms of the master contract, the terms of the master contract will control. The Employer's signature on the application certifies the Employer's agreement to comply with the terms and provisions of the Contract.

The Contract is a guide to the employer coverage and should be kept in a convenient place for quick reference. The purpose of the Contract is to provide, under the circumstances specified herein, benefits to the Employer's covered employees, subscribers, or other eligible plan participants and their dependents (collectively referred to as "Members").

Your coverage is designed with a series of special cost-containment features to help Members use benefits to their best advantage. It is important that you and your Members become familiar with such cost-containment provisions because when used properly, they may help to hold down the cost of medical care and, consequently, keep your group premium from escalating.

Again, thank you for selecting the Company for your insurance needs. We look forward to the opportunity to serve you.

John Martie
President and General Manager
Anthem Blue Cross and Blue Shield
HMO Colorado

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Section I: General Agreement

1. If the Company approves the Employer's application, the effective date of the Contract will be included on the Employer's application when it is returned to the Employer. The Contract will remain in effect, renewing on an annual basis, unless terminated according to the provisions of the Contract.
2. The definitions contained in the Glossary below and the definitions and other terms of the certificate are incorporated herein by reference.
3. The Employer may not assign any of its rights, benefits, duties or obligations without the prior written consent of a duly authorized officer of the Company. However, the Company may assign this Contract to a successor organization or corporate affiliation without the Employer's consent.
4. *Contract Provision Changes:*
   a) This master contract, along with the application, any addenda and endorsements, the acceptance letter, and the certificate, constitute the entire Contract between the parties and supersede all other Contracts, either oral or written, between the parties with respect to the Contract's subject matter. No course of action, usage or custom or internal policy of either the Company or the Employer may amend or become a part of this Contract. Except as provided in paragraphs (b) and (c) immediately below, no change or modification to this Contract will be valid unless the same is in writing and signed by the parties to this Contract.
   b) This Contract may be amended at renewal by an endorsement or the issuance of a revised Contract, signed by a duly authorized officer of the Company; such modification shall be uniformly applied to all Employers, and those Employers affected shall be given the opportunity to purchase other health insurance products offered by the Company with no lapse in coverage. When the endorsement or revised Contract has been so signed and issued by the Company, it shall be deemed binding and effective as of the date specified by the endorsement or revised Contract, without the need for the signature of the Employer or any other entity.
   c) Any amendment resulting from state or federal law or regulation, or ruling or approval by the Commissioner of Insurance of the state in which this Contract is issued, may be made at any time by endorsement to the Contract signed by a duly authorized officer of the Company, and it will become effective as of the effective date of such law, regulation, ruling or approval.
   d) No agent, employee, broker or other person acting on the Company's behalf has the actual or apparent authority to change the Contract or waive any of its provisions, and no change in the Contract will be valid unless approved by an officer of the Company and evidenced by an endorsement, rider, amendment or revision to the Contract signed by a duly authorized officer of the Company. Except as described in paragraph (b) or (c) immediately above, any amendment that reduces or eliminates coverage must have been either requested in writing or approved in writing by the Employer.
5. No Member or Employer is entitled to share in any reserve or other funds that may be accumulated or otherwise owned by the Company, unless and until the Company grants in writing a right to share in such funds.
6. Employers must send notices to the Company by United States mail or personal delivery to the following address: Attn: Membership, 700 Broadway, Denver, CO 80273. The Company will send all notices to employees or the Employer to the last address appearing in the Company's records.

   Notice from the Company to the Employer or Employer's broker/consultant will be effective notice to the Employer and each Member. Such notice will be considered given as of the date the Company sent the notice. The Employer agrees to post each notice promptly in a place that will make it easy for Members to read the notice.

   Notice from the Employer to the Company will be considered given as of the date of mailing or, in the case of personal delivery, as of the date it is placed into the hands of any agent, officer or employee of the person or party to whom such notice or demand is directed. The Company will not be considered an agent of the Employer, nor will the Employer be considered an agent of the Company for any purpose.
7. To the extent not preempted by federal law or regulation, this Contract will be governed, interpreted and enforced to remain in compliance with the laws of the state in which it is issued, along with applicable federal statutes and regulations. Nothing contained in the Contract will be construed as the Company doing business in any state or jurisdiction in which it is not duly authorized.

8. If either party to this Contract seeks the assistance of an attorney for litigating or arbitrating any action against the other party arising in whole or in part from any part of the Contract, the prevailing party will be awarded its reasonable attorneys' fees and entitled to recover said fees from the losing party. In addition, the prevailing party will be entitled to recover all other reasonably incurred costs and expenses from the losing party.

   The Employer shall defend, indemnify and hold harmless the Company and its affiliates, agents and employees (the "Indemnitees") from all costs, including losses, claims, settlements, judgments, fees (including attorneys' fees and other litigation costs) and internal costs resulting from the Indemnitees' participation in lawsuits, arbitration or other legal proceedings related to the Company's obligations, acts or omissions under this Contract. However, nothing herein shall obligate the Employer to indemnify the Indemnitees for acts, omissions or losses resulting solely from the Company's own gross negligence or fraudulent or criminal misconduct.

   The Company shall indemnify and hold harmless the Employer from costs, including losses, claims, judgments and fees (including attorneys' fees and other litigation costs), incurred by the Employer as a result of the Employer's participation in lawsuits, arbitration or other legal proceedings, where such costs and losses result solely from the Company's gross negligence or fraudulent or criminal misconduct. The provisions of this paragraph 8 shall survive termination of the Contract.

9. The Employer acknowledges that no warranties or representations other than those contained in this Contract have been made or given by the Company or its representatives, and that, in entering into this Contract, the Employer has relied solely on the express terms of the Contract and not on any other oral or written statement not incorporated in the Contract.

   All statements contained in applications or enrollment forms made by the Employer or any Member shall be deemed representations and not warranties. No statement shall void the coverage provided hereunder or reduce any benefits unless the statement is contained in a written application or enrollment form signed by the person making the statement, a copy of which has been furnished to the person making the statement. The rights and remedies provided for in this Contract are cumulative and are in addition to, and not exclusive of, any other rights or remedies available by law or otherwise.

10. The failure of either party to enforce or insist on compliance with any provision of this Contract will not be construed as or constitute an election or waiver of the right to enforce or insist on compliance with such provision in the future.

    No failure or delay by the Company to exercise any right or to enforce any obligation under this Contract, and no course of dealing between the Employer and the Company, will operate as an election or waiver of such right or obligation. No single or partial exercise of any right or failure to enforce any obligation under this Contract will prevent any other or further exercise thereof or the right to exercise any other right or enforce any other obligation. No notice or demand on the Employer in any case will entitle the Employer to any other or further notice or demand in other circumstances, or constitute a waiver of the Company's right to any other or further action in any circumstance without notice or demand.

11. *Member Liability Under the BlueCard® Program (applies only to health insurance benefits):*

    a) *For HMO Coverage*

    Like all Blue Cross and Blue Shield Licensees, we participate in a program called "BlueCard". Whenever Members access health care services outside the geographic area we serve, the claim for those services may be processed through BlueCard and presented to us for payment to conformity with network access rules of the BlueCard Policies then in effect ("Policies').

    Members who are traveling or, living outside of the HMO Colorado service area may obtain Emergency Services from a provider participating with an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), where available. **Services that are not Emergency Services are not covered through the BlueCard Program. Urgent Care Services, Follow-up Care and any other services that an HMO Licensee offers must be provided or authorized by a Member's Primary Care Physician.**

    When Members receive covered health care services within the geographic area served by a Host Blue, we will remain responsible to the Employer for fulfilling our contractual obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim: The calculation of Member liability for covered health care services incurred outside the geographic area we serve and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price we pay the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's provider contracts. The negotiated price paid to a Host Blue by us on a claim for health care services processed through BlueCard may represent:

(i) the actual price paid on the claim by the Host Blue to the health care provider ("Actual Price"); or

(ii) an estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care providers or one or more particular providers ("Estimated Price"); or

(iii) an average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers ("Average Price"). An Average Price may result in greater variation to the Member and Employer from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Member is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require the Host Blue to either (1) use a basis for calculating Member liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, we would then calculate Member liability for any covered health care services in accordance with the applicable Host Blue state statute in effect at the time the Member received those services.

Return of Overpayments: Under BlueCard, recoveries from a Host Blue or from participating providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

b) *For POS and PPO Coverage's:*

Like all Blue Cross and Blue Shield Licensees, we participate in a program called "BlueCard". Whenever Member access health care services outside the geographic area we serve, the claim for those services may be processed through BlueCard and presented to us for payment in conformity with network access rules of the BlueCard Policies in effect ("Policies").

Under BlueCard, when Members receive covered health care services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), we will remain responsible to you for fulfilling our contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of BlueCard are described generally below:

Liability Calculation Method Per Claim: The calculation of Member liability on claims for covered health care services incurred outside the geographic area we serve and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price we pay the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's provider contracts. The negotiated price paid to a Host Blue by us on a claim for health care services processed through BlueCard may represent:

(i) the actual price paid on the claim by the Host Blue to the health care provider ("Actual Price"); or

(ii) an estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care providers or one or more particular providers ("Estimated Price"); or

(iii) an average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers ("Average Price"). An Average Price may result in greater variation to the Member and Employer from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Member is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require the Host Blue to either (1) use a basis for calculating Member liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) add a surcharge. Should any state statues mandates liability calculation methods that differ from the negotiated price methodology or require a surcharge, we would then calculate Member liability for any covered health care services in accordance with the applicable Host Blue state statute in effect at the time the Member received those services.

Return of Overpayments: Under BlueCard, recoveries from a Host Blue or from participating providers of a Host Blue can arise in several ways, including but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

12. *Termination of the Contract:*

a) The Employer may terminate the Contract at any time during its term upon giving the Company thirty-one (31) days' advance written notice of termination. The Employer must pay premium for each Member covered through the effective date of the Employer's termination of this Contract.

The Employer shall pay premiums to the Company for each individual covered under this Contract through the date that the Employer notifies the Company that the individual covered under this Contract is no longer eligible or covered or through the effective date of the Employer's termination of this Contract, subject to the additional terms of subparagraph 12(g) below.

b) The Company may terminate the Contract at any time during its term (i) if the Employer fails to meet eligibility requirements; (ii) if the Employer fails to maintain enrollment percentage requirements as provided in the application; (iii) for misrepresentation of material facts or for any other material breach of the Contract; (iv) if the Employer commits a fraudulent act (when this occurs, the Company will recover paid claims); (v) if the Employer does not remit to the Company any assessment billed for CoverColorado or any similar state or federal program; or (vi) for any reason as permitted by applicable law or regulation, upon giving the Employer such advance notice, if any, as may be required by such law or regulation.

c) When this Contract is financed on an alternative (i.e., partially self-insured or shared funding) basis, the Employer's failure to provide the requisite advance written notice of termination will entitle the Company to recover, as liquidated damages, a sum equal to the average of the monthly charges imposed by the Company under such alternative funding arrangement for the ninety (90) days preceding the termination date, or any other termination amount as described in the alternative funding arrangement.

d) If a voluntary or involuntary insolvency or bankruptcy petition under Title 11 of the United States Code is filed by or against the Employer, then within ten (10) days of the petition date the Employer shall file in the bankruptcy court a motion for authority to assume or reject this Contract, effective in either case as of the date the motion is filed. If the Employer fails to timely file such a motion, the Employer acknowledges that the Company may file in the bankruptcy court a motion requiring the Employer to assume or reject this Contract, effective in either case as of the date the motion is filed, and the Employer agrees that it shall not oppose such motion. The Company shall have no obligation to pay any claims under this Contract unless and until all pre-petition and all post-petition premiums have been and are paid in full when due.

e) The Company may terminate the Contract at any time during its term for the Employer's failure to make timely payment of amounts due under the Contract. The Employer is entitled to a grace period of thirty-one (31) days for the payment of any premium or state-mandated special fees due, except for the first payment, which is due upon initial enrollment. If the Employer fails to pay the amounts due under this Contract before the expiration of the applicable grace period, the Company may then treat this Contract as having immediately and automatically terminated, without any further notice or action being required by the Company, and such termination shall be effective as of the last day for which the Employer has made payment due under this Contract.

For Groups with Health Coverage: During the grace period, the Contract shall continue in force unless the Employer gives the Company written notice of termination of the Contract in accordance with the terms of the Contract. If the Employer has obtained replacement coverage as of the Service Date for which premium payment was last received by the Company, the Contact shall be terminated as of the Service Date, and any and all claims paid during the grace period will be retroactively adjusted.

If the Employer has **not** obtained replacement coverage as of the Service Date for which premium was last received by the Company, and the Employer fails to remit payment of premium during the grace period or fails to inform the Company that the Employer does not have replacement coverage, the Company shall process all claims for dates of service during the grace period under the terms of the Contract. The Employer will be liable to the Company for the payment of a pro-rata premium for the time the coverage was in force during such grace period.

f) When the Company or the Employer terminates this Contract, regardless of the reason or manner of termination, within ten (10) days of receipt of notice of termination, the Employer shall notify the Members that this Contract is to be or has been terminated.

g) Except as otherwise provided in the certificate or as required by law, upon termination of the Contract, regardless of the reason or manner of termination, the Company shall cease to have any liability for claims or for the reimbursement of services incurred after the effective date of termination or the end of any applicable grace period (whichever is earlier) and shall have no liability to offer continuation or conversion coverage to Members under the terminated Contract. If the Company remains liable hereunder for a Member's claims which are incurred after termination of this Contract, the Employer shall pay the Company a pro-rata premium for said Member during the period of post-termination coverage. Nothing herein shall be construed as a waiver of the Contract's termination, or as a limitation on the Company's remedies in the event of such termination. The terms of this Paragraph 12 shall survive termination

13. *Reinstatement of Contract:*

a) Reinstatement of a terminated contract is within the Company's sole and absolute discretion.

b) Generally, groups with fifty-one (51) or more eligible employees will not be considered for reinstatement until one (1) year has elapsed from the date of cancellation, if the Employer was cancelled for any of the following reasons:

- Nonpayment of premium
- Failure to make timely premium payments
- The Employer no longer meets eligibility requirements
- The Employer no longer meets enrollment percentage requirements
- Misrepresentation of material facts or any other breach of the contract
- For any other reason, within the law, for which the Company has given the Employer thirty-one (31) days' written notice of the termination

c) An Employer that voluntarily cancels coverage will generally not be considered for re-enrollment until ninety (90) days have elapsed from the date of cancellation if the Employer cancels, for any of the following reasons: (i) the Employer transferred to another insurance carrier, (ii) the Employer self-insures, (iii) the Employer is bought out, (iv) the Employer discontinues providing group health coverage, or (v) any other voluntary cancellation.

14. The Company may change monthly premiums (i) whenever benefits under the Contract or certificate are changed by endorsement or by federal or state law, or (ii) upon giving written notice to the Employer not less than thirty-one (31) days before the effective date of the change.

    In addition to (i) and (ii) immediately above, if, after the effective date of this Contract, any applicable law, regulation, order, consent decree or other legal process binding on the Company requires the Company to remit amounts, rebates or reserves it otherwise would retain, or results in an increased cost to the Company, the Company may, upon 31 days' advance written notice, increase the charge to the Employer by an amount equal to the resulting proportionate additional expense incurred by the Company for the services provided hereunder. Such charge shall be in addition to all other amounts due hereunder, and Employer's failure to pay such additional charge shall be considered a financial default under the terms of this Contract. In addition, the Company reserves the right to review monthly premium whenever a group, section or classification of employees or subscribers is added to or deleted from enrollment under the Contract. The Employer shall notify the Company no later than thirty-one (31) days before the effective date of such addition or deletion, and any change in monthly premium as the result of an increased or decreased total group enrollment will become effective on the same date as such addition to or deletion from total enrollment under the Contract. This provision will apply regardless of the Employer's normal rate review date or any other advance rate notification agreement that may be in effect between the Company and the Employer.

15. *Benefit Changes:*

    a) The Company reserves the right to change the benefit provisions under this Contract, effective on the Anniversary Date, by giving written notice to the Employer not less than thirty (30) days before the effective date of such change; however, such notice requirement will not apply to changes in benefit provisions that are required by state or federal law or regulation. If the Employer requests a change to the benefit provisions under this Contract, it shall give the Company at least forty-five (45) days' advance written notice of the requested change.

    b) If any change to the benefits or the payment amounts is unacceptable to the Employer, the Employer will have the right to terminate coverage under this Contract by giving written notice of termination to the Company before the effective date of the change. If a benefit provision is changed, payment of the new amounts or continued payment of current amounts shall constitute the Employer's acceptance of the change, without the Company being required to obtain the Employer's signature on the schedule and/or addenda. The schedule and/or addenda will then become a part of this Contract.

16. A retroactive refund of membership premium paid beyond the termination date will be granted if the Company receives written notification at least thirty-one (31) days before the termination date **and** benefit payments have not been made on behalf of a Member's claim for services rendered after the termination date.

17. If the Company receives notification less than thirty-one (31) days before the termination date, the Company will make no refund of membership premium.

18. Negotiation or deposit of checks shall not be deemed to be acceptance by the Company of such payment, nor shall such negotiation or deposit of the Employer's check prevent the Company from later returning such payment by issuing a check for the amount of the Employer's check to the Company.

19. Acceptance of payments from the Employer or the payment of benefits to persons no longer eligible will not obligate the Company to provide benefits, except where specifically required by applicable law.

20. This agreement is not workers' compensation insurance.

21. The Employer, on behalf of itself and its Members, expressly acknowledges its understanding that this Contract constitutes a contract solely between the Employer and the Company, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting the Company to use the Blue Cross and Blue Shield Service Marks in the State of Colorado, and that the Company is not contracting as the agent of the Association. The Employer, on behalf of itself and its Members, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person, entity or organization other than the Company and that no person, entity or organization other than the Company shall be held accountable or liable to the Employer for any of the Company's obligations to the Employer created under this Contract. This paragraph will not create any obligations in addition to those described under other provisions of this Contract.

22. *For HMO Coverage*: Written notice of claims submitted by Members must be given to the Company within six (6) months after the occurrence or commencement of any loss covered by the Contract. Failure to give notice within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

    For PPO Coverage: Written notice of claims submitted by Members must be given to the Company within three hundred sixty-five (365) days after the occurrence or commencement of any loss covered by the Contract. Failure to give notice within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

23. It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the Company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

24. Any discounts, rebates or other funds the Company receives from drug manufacturers or similar vendors are not included in premium calculations, and the Company will retain such discounts, rebates or other funds.

25. The Employer has the option of paying its monthly premium via automatic electronic funds transfer. In its sole and absolute discretion, the Company may accept payment of premium via telephone, wire or other acceptable electronic transfer of funds on a non-automatic basis. The Company may charge Employer a fee not to exceed $10 per transfer, whether performed on an automatic, or episodic basis.

26. *Grandfathered Health Plans:* In the event the Employer maintains a grandfathered health plan(s), as that term is used in the Patient Protection and Affordable Care Act ("PPACA"), the Employer shall not make any changes to such plan(s), including, but not limited to, changes with respect to employer contribution levels, without providing the Company with advance written notice of the intent to change such plan(s). Making changes to grandfathered plans without notice to the Company may result in the plan(s) losing grandfathered status and significant penalties and/or fines to the Employer and the Company. In the event the Employer implements changes to its plan(s) and does not provide advance notice to the Company, the Employer agrees to hold harmless the Company from any penalties, fines or other costs assessed against the Company and to reimburse the Company for any such penalties, fines or other costs.

    Additionally, at each renewal after September 23, 2010, the Employer shall affirm in writing, upon reasonable request of the Company, that it has not made changes to its plan(s) that would cause the plan(s) to lose its/their grandfathered status.

Section II: The Company's Obligations

1. The Company will provide health care benefits to Members who receive covered services under the terms of this Contract and the certificate. However, in no event will the Company provide benefits for services rendered before the effective date or after the termination of this Contract, except as provided in the certificate or as specifically required by law. In providing benefits, the Company will apply its applicable medical policies and its utilization review, quality improvement and administrative practices and procedures as adopted from time to time.

2. Unless otherwise agreed to by the Company and the Employer, the Company will deliver to each subscriber's last address appearing in the Company's records a health benefit ID card (except vision only plans). The Company will provide the Employer with an electronic and/or written copy of a membership certificate, which will describe the features of the coverage, including any applicable conversion or continuation privilege, and to whom the benefits are payable, as well as an electronic and/or written copy of the then-current provider directory. The Employer shall be solely responsible for delivering a copy of the certificate and provider directory to each Member, in a manner compliant with the Employee Retirement Income Security Act (ERISA), if applicable. The Employer acknowledges and agrees that the certificate or benefit booklet supplied to the Employer is not the Summary Plan Description within the meaning of ERISA, and that the Employer shall be solely responsible for accurately and completely incorporating the certificate into any Summary Plan Description of the Employer's plan. Notwithstanding the above, the Employer agrees that the Company may, upon advance notice to the Employer, deliver certificates, ID cards, benefit booklets, provider directories or other materials to the Employer and/or Member via electronic means or via Internet access, where permitted by law. In such an event, the Employer is in no way relieved of its obligations under ERISA, other applicable law, or under this Paragraph. If due to the Employer's failure to comply with the obligations of this Paragraph, a court, jury, internal or external appeal board of the Company concludes that a term, exclusion or limitation of the certificate is not enforceable against the Member, the Employer will indemnify Company for any and all costs, including without limitation any attorneys' fees, Company incurs as a result thereof.
3. The Company will furnish appropriate application forms and related materials necessary and appropriate for the enrollment of Members and will provide such assistance as may reasonably be necessary to the Employer for enrollment purposes. The Company will maintain current eligibility status records on all Members, with information submitted by the Employer, for the adjudication of claims.
4. The Company will provide claims forms to the person making the claim or to the Employer for delivery to said person. If the Company does not provide such claim forms within fifteen (15) days after receiving notice of any claim under the Contract, the person making the claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.
5. The Company may employ or contract with any person and may delegate any and all of its responsibilities under this Contract without the consent of the Employer.

Section III: The Employer's Obligations

1. The Employer must maintain contribution and participation levels required by the Company's underwriting regulations and guidelines.
2. If the Employer offers more than one health benefit plan to its employees or subscribers, the Employer shall offer the Company's coverage to all employees/subscribers on terms no less favorable with respect to the Employer's contribution than those applicable to any other health coverage available through the Employer.
3. The Employer will timely provide the Company with information as is reasonably required by the Company for the purposes of determining eligibility for coverage, enrolling and disenrolling Members, determining the amount of premium payable by the Employer, verifying the continued eligibility of the group, or any other purpose reasonably related to the administration of this Contract. The Employer will give notification of eligibility to each employee/subscriber who is or will become eligible for enrollment. The Employer will collect a Member application for each Member who wants to enroll and submit the applications to the Company.
4. The Employer will administer eligibility according to the eligibility guidelines set forth in the Contract. The Employer will furnish the Company with initial information about Members and will thereafter furnish a monthly notice of additions, deletions and changes to this listing on or before the billing date.

a) The Employer will keep such records and furnish to the Company such notification and other information as the Company may require for the purpose of enrolling Members, processing terminations, effecting changes in single or family contract status, effecting changes due to a Member becoming eligible for Medicare, effecting changes due to a Member becoming disabled or being eligible for short-term or long-term disability, determining the amount payable by the Employer under this Contract, or for any other purpose reasonably related to the administration of this Contract. This will include, but is not limited to, the handling of ongoing additions, deletions and changes on a timely basis. The Employer will be responsible for retaining in auditable form complete eligibility documentation, whether written or in electronic form, including, but not limited to, all electronic or written enrollment information, any electronic or written confirmation forms or media, and any electronic or written correspondence related to the eligibility and declination forms. The Employer must procure the Company's prior approval of any non-standard forms to be used in obtaining eligibility information. The Employer warrants that the electronic enrollment processes and media are maintained in a secure manner, are retrievable and reproducible, with the enrollment and signature linked with the process or media. In addition, the Employer warrants that the manner of electronic signature satisfies all legal requirements for an electronic signature. The Employer will furnish to the Company, immediately on the Company's demand and at no expense to the Company, copies of such forms, authorizations and correspondence, whether written or electronic.

b) The Employer shall advise the Company when the Employer has notice that a Member is no longer employed by the Employer or otherwise does not meet membership requirements. The Employer shall so notify the Company, at the latest, by the first Service Date after a Member ceases to be employed by the Employer or otherwise ceases to meet membership requirements. The Employer agrees that no person will be kept on the Employer's payroll or otherwise be represented as a Member for the principal or sole purpose of obtaining or maintaining coverage under this Contract. The Employer agrees to observe the terms of this Contract and hold the Company harmless for all costs and claims incurred or associated with such ineligible individual, including, without limitation, attorney fees and liability incurred in the defense of any claim or suit brought at any time by a person ineligible for coverage.

c) The Employer shall remit premiums to the Company for each individual covered under this Contract through the date that the Employer notifies the Company that the individual covered under this Contract is no longer eligible or covered. The Company must receive notification that an Member is no longer eligible or covered, at the latest, by the end of the month that the Member becomes ineligible for such termination to be effective that month. If the Company receives notification that a Member is no longer eligible after the end of the month that the Member becomes ineligible, the termination will be processed as effective on the date the Company receives notification. Notwithstanding the above, premiums shall be paid pursuant to the premium payment provisions of this Contract.

5. If the Employer reduces the working hours of employees to fewer hours than stated on the application, coverage will be continued for such employees and their dependents under the same conditions and for the same premium, if the following conditions are met and the Employer so certifies:

   a) The covered employees are continuously employed as employees of the Employer and are insured under the Contract, or under any contract providing similar benefits which said Contract replaces, immediately before such reduction in working hours;

   b) The Employer has imposed such reduction in working hours due to economic conditions, or the reduction of hours is due to the employee's injury, disability, or chronic health condition; and

   c) The Employer intends to restore the employees to a full workweek schedule as soon as economic conditions improve or as soon as the employee is able to return to full-time work.

6. The Employer agrees to (i) act as remitting agent for the enrolled Members, (ii) make payroll deductions for that part of premium not otherwise provided for by the Employer, **and** (iii) remit all premiums and any state-mandated special fees to the Company not later than the due date for each remitting period. Nothing in this Contract will make the Employer the agent of the Company.

7. The Company shall not have any obligation to accept partial premium payment. The Employer shall make such payments regardless of any contributions to premium payments by Subscribers. The Employer shall have the responsibility for collecting and remitting payments to the Company as they come due. Even if the Employer has not received a premium bill from the Company, the Employer is still obligated to pay, at a minimum, the amount of the prior premium bill. The Company shall not assume any liability to Members or any other individual by reason, in whole or in part, of any delay or failure of the Employer to remit applicable payments.

8. Initial premium shall become payable on or before the effective date of the Contract. Subsequent premiums will be payable on or before the established Service Date of each month thereafter. Claims processing and payment will be pended if premium is not timely paid. **In no event shall coverage under the Contract become effective until the Company accepts the application and the Company receives payment of the initial premium.**
9. The Employer will designate a person as the principal contact for all matters related to the Employer's group coverage. That person (referred to as the group administrator) will assist Members in the administration and payment of claims. The Employer understands that the Company is acting as a claims administrator and is not the "Plan Administrator" or other Named Fiduciary, for purposes of ERISA. As claims administrator, the Company assumes only those responsibilities expressly agreed to under this Contract. Nothing contained in this Contract will designate or render the Company an ERISA plan's agent for service of legal process.
10. The Employer must make the insurance coverage available to all eligible Members.
11. The Employer will permit the Company or a representative appointed by the Company to perform a payroll audit.
12. The Employer will maintain records and furnish to the Company or its designated agent(s) any information, including tax records, required in connection with administration of the insurance coverage.
13. The Employer will notify eligible Members of their applicable conversion rights and rights to continue health coverage under COBRA or State Continuation law.
14. The Employer agrees not to impede any Member from performing his or her obligations under the certificate and to assist Members in performing their obligations to the extent consistent with this Contract.
15. The Employer shall comply with all applicable local, state and federal laws, rules and regulations, including, but not limited to, COBRA, ERISA, the Family and Medical Leave Act, the ADA, ADEA, Title VII, TEFRA, DEFRA and OBRA.

Section IV: Member Eligibility

1. Eligible employees with a regular work week as indicated on the application have been paid for such employment by the Employer, have satisfied the Company's underwriting regulations and are listed as an employee on the Employer's state unemployment insurance tax returns, and the dependents of the employees will be initially enrolled on the Contract's effective date for the type of coverage elected in such application. Where the plan sponsor is not an employer (e.g. a union, school or other legitimate entity), those Members which satisfy the plan sponsor's eligibility requirements will be initially enrolled on the Contract's effective date for the type of coverage elected in the application. The Company may inspect such public and private records as are necessary to verify eligibility.
2. The Employer will have the opportunity to submit applications to add new and transferred Members to the group of Members initially enrolled under this Contract. Addition of the Members will be made according to the Company's underwriting regulations and the following procedures:
   a) Applications will be submitted on behalf of all eligible new or transferred Members who want to enroll at the time of hiring, transfer or other eligibility. Applications will specify the date of hire for new employees, the date of transfer for transferred employees, or the date of eligibility for other new participants. However, such employee may be required to complete a health questionnaire as part of the application process, and the answers the employee supplies on the questionnaire will not prevent enrollment. The Company may impose a pre-existing condition waiting period to the extent permitted by law.
   b) The effective date of coverage for any such additional Member whose application the Company accepts will be in accordance with the Company's underwriting regulations in effect at the time the Member's application is approved and in accordance with the provisions of the certificate.
   c) Eligible employees or plan participants enrolled in another benefit plan or alternative delivery system (including, but not limited to, a health maintenance organization or preferred provider organization) offered by the Employer may submit applications to the Company (at annual enrollment, if applicable).

d) Employees or plan participants who do not enroll will be recorded accordingly. Such record will become part of the Employer's data and will constitute a waiver of coverage under this Contract. The Employer will also keep a record of employees or plan participants who did not apply because they have health care coverage through another source.

e) Employees who are returning from an absence from work due to a health-related absence or disability, maternity leave, or regularly scheduled vacation are not subject to the provisions immediately above.

3. The Company must receive applications for Member coverage within thirty-one (31) days of the Contract's effective date or within thirty-one (31) days of eligibility for coverage, whichever is later. If the Company does not receive the application within this time period, the Member is subject to the Company's current underwriting regulations and state or federal law for provisions for late enrollees.

4. An eligible Member who did not request enrollment for coverage during the initial enrollment period or special enrollment period, or a newly eligible dependent who failed to qualify when first entitled to enroll, may apply for coverage as a late enrollee. Such Member may only enroll during an annual enrollment and may be required to complete a health questionnaire as part of the application process, and the answers such Member supplies on the questionnaire will not prevent enrollment. The Company may impose a pre-existing condition waiting period to the extent permitted by law and as described in the certificate.

5. Subject to the terms of the certificate, a person who meets one of the following conditions may enroll during a special enrollment period:

a) The person is an eligible employee or eligible dependent who initially declined this coverage due to other health care coverage and who completed a Waiver of Group Health Coverage Form; when the other health coverage was (a) COBRA or State Continuation coverage that was subsequently exhausted; or (b) terminated as a result of loss of eligibility for that coverage (due to legal separation, divorce, revocation or termination of a designated beneficiary agreement or domestic partnership if coverage for designated beneficiary or domestic partner is offered by the Employer, death, termination of employment or reduction in the number of employment hours); or (c) terminated as a result of Employer contributions toward such coverage ceasing; (2) the person has become a dependent of an employee through marriage, a designated beneficiary agreement or domestic partnership if coverage for designated beneficiary or domestic partner is offered by the Employer, birth, adoption or placement for adoption; or (3) the person is an eligible employee who initially declined coverage, regardless of the reason, and who subsequently acquires a dependent through marriage, a designated beneficiary agreement or domestic partnership if coverage for designated beneficiary or domestic partner is offered by the Employer, birth, adoption or placement for adoption and requests to enroll at the same time as the newly acquired dependent(s).

b) Enrollment under provision (a) must be requested no later than thirty-one (31) days after the date the coverage described above terminated or the date the person becomes a dependent of an eligible employee. If enrollment is not requested within the required thirty-one (31) days, the person will be considered a late enrollee. Such employee or dependent may be required to complete a health questionnaire as part of the application process, and the answers supplied by the employee or dependent on the questionnaire will not prevent enrollment. The Company may impose a pre-existing condition waiting period to the extent permitted by law and as described in the certificate.

c) The person is an eligible employee or eligible dependent who has (1) lost coverage under a state Medicaid program or State Children's Health Insurance Program; or (2) become eligible for premium assistance with respect to coverage under the employer's health coverage, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans.

d) Enrollment under provision (c) must be requested no later than sixty (60) days after the date that state Medicaid coverage terminated, or ninety (90) days after the date that SCHIP coverage terminated. With respect to premium assistance eligibility, enrollment under the employer plan must be requested no later than sixty (60) days after the eligibility date for assistance is determined. If enrollment is not requested within these timeframes, the person will be considered a late enrollee. Such employee or dependent may be required to complete a health questionnaire as part of the application process, and the answers supplied by the employee or dependent on the questionnaire will not prevent enrollment. The Company may impose a pre-existing condition waiting period to the extent permitted by law and as described in the certificate.

6. Coverage under this Contract for Members enrolled on or before the effective date of this Contract will commence as of such effective date, subject to the provisions of the certificate. Thereafter, coverage for any eligible Member who submits a timely enrollment application will begin on the date determined by the Company.

7. Regarding the continuation coverage requirements of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or any other applicable state law, the Company will allow continued coverage under this Contract only for those qualified beneficiaries under COBRA or such state law who have been timely notified of their continuation rights and have timely elected and paid for the continued coverage, and only to the extent required by COBRA or applicable state law. The Employer further understands and agrees that any notice, collection of premium or communication about continuation coverage will be the responsibility of the Employer (or employee where applicable) and not the Company.

8. The Employer acknowledges that it is the Employer's obligation under the FMLA to maintain group health benefits on the same conditions as if the employee had been continuously working during the entire period. The Employer's act of keeping the coverage in force ensures that the Employer will be able to comply with its obligation under the FMLA to provide equivalent benefits to employees returning from FMLA leave without any requalification requirements. If the employee does not retain coverage during the leave period, the employee and any eligible dependents that were covered immediately before the leave may be reinstated upon return to work and without the imposition of any waiting periods. To obtain coverage for an employee upon return from FMLA leave, the Employer must provide the Company with evidence satisfactory to the Company of the applicability of the FMLA to the employee's leave, including a copy of the health care provider statement allowed by the FMLA.

9. The Company reserves the right to cancel or rescind any health care benefits provided under this Contract to any individual who engages in misrepresentation and/or fraudulent conduct, as determined by the Company, in relation to any claims made for coverage or any application for coverage under this Contract. In addition, the Company reserves the right to cancel or terminate coverage provided under this Contract to any individual who has erroneously been represented by the Employer or the Member as being eligible for coverage under this Contract, and reserves the right to terminate any individual's coverage in accordance with cancellation and termination provisions in the individual's certificate.

10. *ELECTRONIC ELIGIBILITY ADMINISTRATION.* If the Employer submits eligibility electronically:

    a. On or before the end of each month, the Employer will transmit to the Company eligibility information electronically, using mutually acceptable software, which will contain a current listing for that month of all Members enrolled under the Contract as of the premium due date. Such listing will include the addition of newly enrolled members, the deletion of persons who are no longer eligible, and any other changes related to eligibility.

    b. Upon receipt of the information from the Employer, the Company will update its membership data with the current enrollment information contained therein according to Company's usual business practices and timeframes.

    c. *Establishment and Retention of Membership Information.* The Employer will provide for the establishment and ongoing retention of membership information as set forth in this Contract.

    d. *Indemnification.* The Employer agrees to indemnify and hold the Company harmless against any claim, demand, loss, lawsuit, settlement, judgment, other liability, and all related expenses which may accrue, arising from or related to the Employer's failure to provide timely, accurate and complete eligibility information in accordance with this "Electronic Eligibility" provision. If the Company is required to provide coverage because of the Employer's failure to fully and faithfully perform under this provision, in addition to any other remedy the Company may have against the Employer for such failure, the Employer will, at the Company's option, pay all prepaid/premium charges due for such coverage or, where permitted by law, reimburse the Company for all claims paid as a result of the Employer's failure.

Section V: Miscellaneous

1. The Company does not undertake to furnish any health care services but will pay for such services furnished to Members as provided for under and limited by this Contract, including the certificates issued under this Contract. Nothing contained in this Contract will give the Employer or Members any right or cause of action, either at law or in equity, against the Company or any of its medical directors, employees or agents for acts or omissions of any hospital or other health care providers from which any Members receive service.
2. If the Employer requests information records or data reports from the Company (and if the Company in its sole discretion agrees to provide such records or reports) that differ substantially in substance or form, in the Company's opinion, from information records or data reports prepared by the Company in the ordinary course of business, the Company will be entitled to fix a reasonable charge for providing such reports, and such charge will be payable at a mutually agreeable time.
3. If any provision of this Contract or its applicability to any person or circumstance is held invalid by a competent judiciary or regulatory authority, such ruling will not affect the validity or enforceability of any other provision of this Contract. If any applicable law or regulation requires that a particular term or provision be included in this Contract, the Contract shall be interpreted and enforced as if such term or provision was specifically stated in this Contract.
4. Coordination of benefits will be as described in the certificate.
5. The Employer and the Company are separate legal entities. Nothing contained in this Contract will be considered to constitute the Employer and the Company as partners, or as employees, agents or representatives of one another, nor will either party have the expressed or implied right or authority to assume or create any obligation on behalf of, or in the name of, the other party through its actions, omissions or representations.
6. Except as specifically described in this Contract, the Employer is not responsible for the services provided under and the benefits of the insurance coverage offered in connection with this Contract but is simply agreeing that its eligible employees or plan participants have the option of enrolling in the health care benefits program offered by the Company. In holding itself out to perform services under this Contract, the Company does not act as an agent for, or for the benefit of, the Employer.
7. For purposes of this paragraph, the following definitions have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations under HIPAA:
   a) "Group Health Plan" as defined at 45 CFR Part 160, Sec. 160.103
   b) "Protected Health Information" (PHI) as defined at 45 CFR Part 164, Sec. 164.501
   c) "Summary Health Information" as defined at 45 CFR Part 164, Sec. 164.504(a)
8. Disclosing information to the Employer:
   a) The Company may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids from health insurers, HMOs or other third-party payers under the group health plan, or for modifying, amending or terminating the group health plan.
   b) The Company may disclose PHI to the Employer to enable the Employer to carry out plan administration functions, but such disclosure may occur only upon receipt of a certification from the Employer that:
   - The Employer's plan documents include all the requirements described in 45 CFR Part 164, Sec. 164.504(f)(2)(i), (ii) and (iii);
   - The Employer has provided notice to those individuals about whom the PHI relates that meets the requirements of 45 CFR Part 164, Sec. 164.520(B)(1)(iii)(C); and
   - That such PHI will not be used for the purpose of employment-related actions or decisions or in connection with any other benefits or employee benefits plan of the Employer.
9. The headings to the sections of this Contract will be disregarded in its interpretation.

10. The Company will have authority to pursue recovery of benefits provided on behalf of Members under this Contract. Such authority includes subrogation recoveries, as well as other available recoveries or refunds. The Company will have authority to establish recovery policies, determine which recoveries are to be pursued and compromise recovery amounts. The Company will not pursue recoveries for overpayments if the cost of collection would exceed the overpayment amount. If the Company would recover the overpayment amount through an automatic recoupment mechanism, the Company will not pursue such recovery if the overpayment was less than ten dollars ($10.00). If the Company would recover the overpayment amount through manual recovery, the Company will not pursue such recovery if the overpayment was less than seventy-five dollars ($75.00).

11. Certain facts are needed to process subrogation recoveries. The Company has the right to decide which facts are needed. The Company may get necessary facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any Member to investigate, obtain or provide such facts except where specifically required by law. Each Member claiming benefits under this Contract must give the Company any facts needed to process any claim and pursue any subrogation recovery. For benefits paid pursuant to this Contract, the authority granted by the provisions of this paragraph 11 will survive termination of this Contract.

12. All Members enrolled under this Contract will have only the rights and benefits, and will be subject to the terms and conditions, described in this Contract.

13. The Company makes no representations or warranties, express or implied, about whether the Employer's health benefits plan, as administered and implemented by the Employer, complies with state and federal laws.

14. The Company agrees to treat all proprietary information about the Employer's operations and the plan in a confidential manner. The Employer agrees to treat all information about the Company's business operations, ideas, know-how, trade secrets, discount information and other proprietary data in a confidential manner. Neither party will disclose any such information to any other person, entity or organization without the prior written consent of the party to whom the information pertains, provided, however, and notwithstanding any other provision in this Contract to the contrary, that the Company may disclose such information to its legal advisors, lenders and business advisors, and the Company may also make such disclosures as are required or appropriate under the Securities Act of 1933, as amended, the Securities Exchange Act of 1934, as amended, and other applicable securities laws and rules of the New York Stock Exchange. Nothing in this provision will prohibit the disclosure of any information required by law, but if any such disclosure occurs, the disclosing party will immediately notify the other party in writing, detailing the circumstances and extent of the disclosure. The Company agrees to use its best efforts to treat all Members' medical records and information concerning claims, conditions or treatment in a confidential manner. The Company will not disclose such confidential information except as authorized by the Member or as permitted by law. The provisions of this paragraph 14 will survive termination of this Contract.

15. The parties acknowledge that neither the Company nor its medical directors, employees or agents are engaged in the practice of medicine; the Company merely makes decisions regarding the coverage of services. Contracted physicians and other medical providers acknowledge and agree within the provisions of their participation agreements that they must exercise independent medical judgment regarding the treatment of their patients, regardless of the Company's coverage determinations.

16. The validity of this Contract will not be contested after it has been in force for two years from the effective date. However, it may be contested at any time for nonpayment of premiums.

17. Neither party will be in breach of this Contract if such party's breach or inability to perform was due to a reason beyond its reasonable control, including, without limitation, acts of God, acts of any public enemy, acts of terrorists, acts of war, floods, statutory or other laws, regulations, rules, or orders of the federal, state or local government or any agency thereof.

18. The Employer agrees and understands that the master contract, together with any addenda and endorsements, the application, the acceptance letter, and the certificate are the controlling documents for all legal purposes. If the Employer does not issue the certificates or provides the Members with any information that is inconsistent with said certificates, the Company is not responsible for any conflict that may arise. The terms of the Contract (including the certificate) may not be altered without the advance written agreement of the Company.

19. Each party submits to the jurisdiction of any state or federal court sitting in the city and county of Denver, Colorado, in any action or proceeding arising out of or relating to this Contract. The parties agree that, unless waived in writing by the Company, all claims related to such action or proceeding may be heard and determined in any such court. Except as provided in this Contract, each party also agrees not to bring any action or proceeding arising out of or relating to this Contract in any other court. Each party waives any defense of inconvenient forum to the maintenance of any action or proceeding so brought and waives any bond, surety or other security that may be required of any other party with respect to such action or proceeding.

20. The premium rates calculated for the Employer are contingent on the accuracy of the eligibility data on Members that the Employer submits to the Company. The Company reserves the right to review such rates upon receipt of all individual applications for the Employer's Members and to modify the rates if the enrollment information warrants such modification. Any misstatements on Members' applications before the coverage effective date may result in a material change to the Employer's coverage or premium rates as of the coverage effective date.

21. *For PPO Health Policies Only:* The Company may apply a six (6)-month pre-existing condition limitation period for certain Members who have no prior creditable coverage. A copy of the prior carrier's billing statement, the individual's certificate of creditable coverage, or other sufficient proof of prior coverage may be requested by the Company to ascertain and document a Member's prior coverage.

22. The Employer represents and warrants that it is in compliance with all applicable local, state and federal laws, rules and regulations, including, but not limited to, COBRA, the Family Medical Leave Act, TEFRA, DEFRA and OBRA. If any part of this Contract is inconsistent with such laws, rules and regulations, such provision will not be considered a part of this Contract. However, the Contract will be otherwise enforceable. If the Employer has agreed to have the Company perform specific billing and notification duties related to COBRA, such information will be stated on the application.

23. If the Company approves the application and issues coverage, the Contract between the parties will consist of this Employer master contract, the application, any addenda and endorsements, the certificate, and the acceptance letter, whether or not these documents are physically attached. The Employer agrees to abide by the terms, conditions and limitations contained in these documents. In resolving any conflict between the terms of the certificate, the master Contract, the application, any addenda and endorsements, and/or the acceptance letter, the terms of the certificate will control over the master Contract and any addenda or endorsements, the terms of the master Contract and any addenda or endorsements will control over the acceptance letter, and the terms of the acceptance letter will control over the application.

24. The Employer represents that it is not a small Employer under applicable law of the state where it is domiciled.

25. Approval of the insurance coverage under this Contract may cancel any prior contracts and/or coverage with the Company, effective immediately preceding the effective date of the Employer's coverage.

26. Employers with ten (10) or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates. Employers have the right to see premium quoted either way. The total premium will initially be the same based on the enrollment assumption used to prepare the quote. However, subsequent enrollment changes could result in premium differences depending on the rate method selected. Composite rates use average rates by coverage type, while age rates use the actual rates for each individual in the group based on the age of the employee.

Glossary

For purposes of this Contract and any addenda, schedules or endorsements to this Contract, the following words and terms have the following meanings, unless the context or use clearly indicates another meaning or intent. Capitalized words and terms not defined below are defined in the certificate.

Anniversary Date – The effective date (i) for enrollment or for coverage changes to the employee membership **or** (ii) for group enrollment and benefit eligibility implemented by the Employer.

Certificate – The certificate of coverage issued pursuant to this Contract that describes the health care benefits provided by the Company and agreed to by the Employer, and provided in accordance with the Company's administrative practices and procedures, including applicable schedules, riders, endorsements and amendments.

Contract – This master contract, any addenda or endorsements, the certificate, the Employer application, and the acceptance letter, which constitute the entire Contract between the parties. The Contract supersedes all prior statements or agreements between the parties, whether written or oral, and may only be modified in accordance with the Contract.

Employee/Subscriber – An employee or other eligible plan participant (not including dependents) as defined in the application as eligible for enrollment; the employee is the subscriber, and health benefit ID cards for the employee and his or her covered dependents are issued in the name of the employee as the subscriber.

Employer – The employer or organization (e.g. union, school, association, etc) with whom the Company has hereby contracted, and by reason of the Contract, the Employer's employees and their dependents become eligible for the coverage and benefits described in the Contract.

Employer's Plan – The employee welfare benefit plan, or other defined program, through which the Employer provides certain health benefits to eligible plan participants.

Member – An individual (whether the employee/subscriber or an eligible dependent) eligible and duly enrolled under the Employer's plan and eligible for coverage under the terms of this Contract.

Service Date – The 1st or 16th day of the month as established for the group for billing purposes (the "due date").